MARKET CONDUCT EXAMINATION REPORT

AS OF DECEMBER 31, 2003

World Insurance Company
11808 Grant Street
Omaha, NE 68164

NAIC Group Code 0251
NAIC Company Code 70629

EXAMINATION PERFORMED BY INDEPENDENT CONTRACTORS FOR

COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

World Insurance Company
11808 Grant Street
Omaha, NE 68164

MARKET CONDUCT EXAMINATION REPORT
as of
December 31, 2003

Examination Performed by

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP
Lynn L. Zukus, AIE, FLMI

Independent Contract Examiners

June 11, 2004

The Honorable Doug Dean
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of World Insurance Company was conducted pursuant to Sections 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-216, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine insurance companies. We examined the Company's records at its office located at 11808 Grant St., Omaha, NE 68164. The market conduct examination covered the period from January 1, 2003 through December 31, 2003.

The results of the examination are respectfully submitted by the following independent market conduct examiners.

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP

Lynn L. Zukus, AIE, FLMI

MARKET CONDUCT
EXAMINATION REPORT
OF
WORLD INSURANCE COMPANY

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COMPANY PROFILE

World Insurance Company has been active in the Colorado market for more than 60 years, establishing its first general agency in the state on May 4, 1938.

The Company has operated through a variety of brokerage systems, currently using a general agent brokerage system with agent brokers serving as the primary sales force. All general agents and agents are contracted representatives, not company employees.

For a period during the early-to-mid 1990's, World focused more on personal producing general agents, a system built around smaller agencies. In 1997, following the merger of MidAmerican Mutual Life Insurance into World Insurance, larger general agency brokers made up much of the Company's sales force in the state. That type of distribution structure continues to be used today. On June 1, 2000, World Insurance Company acquired Mid-South Insurance Company, an accident and health insurer, from Trigon Healthcare, Inc.

The Vice President of Marketing led marketing functions through 2003 followed by the Executive Vice President, Secretary and Chief Marketing Officer using Independent Marketing Organization along with the Company's traditional brokerage sales force through 2003. Using their managers and staff, the marketing officers distributed World's products through the general agent brokers and their agent brokers, all contracted representatives, not employees.

In recent years World Insurance has added some large Independent Marketing Organizations selling Association Group coverage, but not to small employers in the state of Colorado.

World Insurance Company is licensed in all states except Alaska, Massachusetts, New Jersey and New York. The same basic marketing structure is used everywhere.

Effective January 13, 2004, the mutual holding companies of World and American Republic Insurance Company were merged. This action made World a sister company to American Republic, both under American Enterprise Holding, Inc.

The Company's Accident and Health direct written premium in Colorado for 2002 was $13,940,000, representing 0.79% of the market share. The Company's loss ratio in Colorado for 2002 was 69.35%. A. M. Best, in a May 6, 2003 Report Revision, assigned a Best's Rating of B++ (Very Good). The Company was assigned a Financial Size Category of Class VII.

PURPOSE AND SCOPE OF EXAMINATION

Independent examiners, contracting with the Colorado Division of Insurance (DOI), reviewed certain business practices of World Insurance Company in accordance with Sections 10-1-202, 10-1-203, 10-1-204, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to sickness and accident insurance plans for individuals. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the limited examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The market conduct examination covered the period from January 1, 2003 through December 31, 2003.

The limited examination included review of the following:

Company Operations/Management
Policy Forms
Rating
Applications
Cancellations/Non-Renewals/Declinations
Claims
Utilization Review

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero ($0) tolerance level was applied in order to identify possible system errors. Additionally a zero ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception

rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

For the period under examination, the examiners included statutory citations and regulatory references related to individual insurance laws. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and Colorado regulations. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1104	Unfair methods of competition and unfair or deceptive acts or practices
Section 10-7-109	Suicide no defense for nonpayment
Section 10-8-513	Eligibility for coverage under the program
Section 10-8-521	Notice to residents
Section 10-8-601.5	Applicability and Scope
Section 10-8-602	Definitions
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Section 10-20-102	Legislative declaration
Section 10-20-103	Definitions
Amended Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Automobile Private Passenger Forms, and Claims-Made Liability Forms
Regulation 1-1-7	Market Conduct Record Retention
Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Repromulgated Regulation 4-2-1	Replacement Of Accident And Sickness Insurance
Regulation 4-2-5	Hospital Definition
Amended Regulation 4-2-6	Concerning The Definition Of The Term "Complications Of Pregnancy"
Amended Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Amended Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans

Amended Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Amended Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Amended Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One
Amended Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Amended Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form And Eligibility Requirements
Amended Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Regulation 4-6-9	Conversion Coverage
Amended Regulation 5-2-3	Auto Accident Reparations Act (No-Fault) Rules and Regulations

Company Operations/Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, and timely cooperation with the examination process.

Policy Forms

The examiners reviewed the following Policy Forms, Applications, Endorsements and Rider Forms.

FORM NUMBER	FORM NAME
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy
G1025-CO	Application for Coverage
G1050-CO	Application for Coverage (replaced Form G1025 eff. 08/25/03)
R1146-CO	Life Benefits for Insured Rider
R1147-CO	Life Benefits for Covered Spouse Rider
R1148	Outpatient Accident Benefit Rider
R1144	Foreign Travel Benefit Endorsement
R1160	MSA Endorsement
W1130 (12-99)	Determination of Self-Employed Business Group of One Form
W1157-CO	Grievance Procedures
LS116301	Uninsurable Plan Notice Form

The most frequently sold individual plan in Colorado in 2003 was the Major Medical PPO Policy, Form A4024.

Rating

The examiners reviewed a randomly selected sample of the rates charged in the sample of files used in the Underwriting-Application section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period.

Applications

For cases that were initially effective or renewed during the period from January 1, 2003 through December 31, 2003, the examiners used ACL™ software to randomly select 100 individual (50 new and 50 renewal business) application files. These files were reviewed for compliance with Colorado insurance law.

Cancellations/Non-Renewals/Declinations

For individual cases that terminated (were cancelled, non-renewed, rescinded or declined) during the period under examination, the examiners used ACL™ software to randomly select a sample of fifty (50) cancelled/non-renewed files. The population of six (6) declined files was used as the sample. These files were reviewed to determine if the procedures used for cancellations, non-renewals and declinations were in compliance with Colorado insurance law and contractual obligations.

Claims

The examiners used ACL™ software to randomly select samples of electronically received and non-electronically received individual claims that were reviewed for timeliness of processing only. Additionally, any claims absent fraud that were not paid, denied or settled within ninety (90) days of receipt were identified. Valid exceptions in all of these categories were included in one issue.

The examiners used ACL™ software to randomly select samples of fifty (50) Paid claims and fifty (50) Denied claims that were reviewed for the Company's overall claims handling practices. These claims were all received during the examination period of January 1, 2003 through December 31, 2003.

Utilization Review

The Company indicated that they did not conduct, nor have any entity conduct for them, Utilization Review during 2003. Utilization Review had been discontinued by the Company in 2001. As a result, there were no files to be examined.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty-three (23) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

- **Company Operations/Management:** The examiners found two (2) areas of concern in their review of company operations and management. The following issues were identified:

    1. Failure to reflect some forms on the Company's Annual Report of Forms in use in 2003.

    2. Certifying and using forms that do not comply with Colorado insurance law.

It is recommended that the Company establish procedures to ensure that all forms in use during a particular year are reported on the Annual Report of Forms and that the Company develop, implement, and monitor the necessary procedures to ensure that all forms to be issued or delivered to Colorado insureds comply with statutory mandates as certified to by an officer of the Company.

- **Policy Forms:** The examiners found fifteen (15) areas of concern in their review of the most frequently sold individual policy forms in use during the year under examination. The following issues were identified:

    1. Failure to reflect correct or complete questions on the form used for determining if an applicant is a self-employed business group of one.

    2. Failure to reflect all required information in application forms concerning replacement of coverage.

    3. Failure to display a Fraud Warning that is substantially the same as required by Colorado insurance law.

    4. Failure to disclose the existence and availability of an access plan in the most frequently sold policy in Colorado.

    5. Failure to reflect wording that would allow coverage for self-inflicted injuries sustained by an insane person.

    6. Failure to give creditable coverage towards preexisting condition exclusions for certain conditions.

    7. Failure to provide benefits for covered services based on a licensed provider's status, e.g., a family member.

8. Failure to reflect correct covered benefits for prosthetic devices.

9. Failure to reflect correct requirements for individual health plans sold to business groups of one to be regulated as individual plans instead of small group plans.

10. Failure to reflect complete benefits for mandated preventive child health supervision services.

11. Failure to reflect correctly and completely the extent of coverage to be provided for home health and hospice care services.

12. Failure to reflect a required policy provision.

13. Failure to reflect correct information concerning non-renewal of health benefit plans.

14. Failure to allow life benefits in the event of suicide after the first policy year.

15. Failure to reflect the correct percentage of late payment interest to be paid on benefits.

It is recommended that the Company review and revise all applicable policy forms to comply with individual sickness and accident laws and regulations.

- **Rating:** The examiners found no areas of concern in their review of the rates and associated required rate filings.

- **Applications:** The examiners found one (1) area of concern in their review of application files for the examination period.

    1. Failure to automatically provide Colorado Health Plan Description Forms during the application process.

It is recommended that the Company establish procedures to ensure that Colorado Health Plan Description Forms are automatically provided during the application process.

- **Cancellations/Non-Renewals/Declinations:** The examiners found one (1) area of concern during the review of the cancellation/non-renewal/declination files. The following issue was identified:

    1. Failure to reflect correct or complete information on Certificates of Creditable Coverage.

It is recommended that the Company establish procedures to ensure that Certificates of Creditable Coverage are completed correctly and completely in compliance with Colorado insurance law.

- **Claims:** The examiners found four (4) areas of concern in their review of the claims handling practices of the Company. The following issues were identified:

    1. Failure in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law.

    2. Failure to accurately determine the number of days utilized for claim processing.

    3. Failure, in some cases, to accurately process claims.

    4. Failure to pay applicable late payment penalties and in some cases, late payment interest.

It is recommended that the Company establish procedures to ensure payment, denial or settlement of claims within the time periods required by law. Additionally procedures should be established to ensure that the number of days utilized for claim processing is calculated correctly, that late payment interest and penalties are paid in all applicable instances and claim procedures should be reviewed to ensure accuracy of benefit payments in all cases.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance.

Results of previous Market Conduct Exams are available on the Colorado Division of Insurance's website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

WORLD INSURANCE COMPANY

COMPANY OPERATIONS / MANAGEMENT FINDINGS

Issue A1: Failure to reflect some forms on the Company's Annual Report of Forms in use in 2003.

Section 10-16-107.2, C.R.S., Filing of health policies, states:

> (1) All sickness and accident insurers, health maintenance organizations, and nonprofit hospital and health service corporations authorized by the commissioner to conduct business in Colorado *shall submit an annual report to the commissioner listing any policy form, endorsement, or rider* for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. … [Emphasis added.]

The two (2) forms identified below were used with the Company's most frequently sold plan in Colorado in 2003. Neither of these forms is reflected on the Company's Annual Report of Forms in use during 2003.

Form Number	Form Name
R1160	Certificate/Policy Endorsement (MSA)
W1157-CO (6-02)	Grievance Procedures

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-107.2, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all forms in use during a particular year are reported on the Annual Report of Forms.

Issue A2: Certifying and using forms that do not comply with Colorado insurance law.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> (1)(s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

An officer of the Company must certify compliance with Colorado insurance law with all initial filings of policy forms and on the annual report of policy forms. It appears that the Company is not in compliance with Colorado insurance law in that not all forms that were certified and used by the Company were in compliance with statutory mandates as evidenced by Issues E1 through E18.

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that evidence of coverage forms to be issued or delivered to Colorado insureds comply with statutory mandates as certified to by an officer of the Company, and as required by Colorado insurance law.

UNDERWRITING
POLICY FORMS
FINDINGS

Issue E1: Failure to reflect correct information on the forms used for determining if an applicant is a self-employed business group of one.

Section 10-8-601.5, C.R.S., Applicability and scope, states:

> (1)(c)(I) Effective October 1, 1997, the provisions of this article and article 16 of this title concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met:
>
> (A) As part of the application process, the carrier determines whether or not the applicant is a self-employed person who meets the definition of a business group of one pursuant to section 10-8-602 (2.5).

Amended Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One, promulgated pursuant to Sections 10-1-109(1), 10-8-601.5(1)(c)(1) and (3), 10-16-108.5(8), and 10-16-109, C.R.S., states:

> V. Rules
>
> A. An individual health benefit plan marketed and/or newly issued on or after October 1, 1997, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself, and the application for coverage meet all the following conditions:
>
> 1. Pursuant to Section 10-8-601.5(1)(c)(1)(A), C.R.S., the carrier issuing the policy shall determine whether or not the applicant is a self-employed business group of one. A carrier shall meet this requirement by having all applicants fill out the "Determination of Self-Employed Business Group of One Form" available from the Colorado Division of Insurance. A copy of the completed form shall be kept on file with each application. … Applicants who answer "yes" to all the questions in the form and, if required by the carrier, who can document their answers shall be considered to have met the test of a self-employed business group of one. …

Bulletin No. 12-01, Determination of Self-Employed Business Group of One Form and Disclosure form for Self-Employed Business Groups of One Applying for Individual Health Benefit Plans, states:

> I. Background and Purpose

The purpose of this bulletin is to provide the form and disclosures required in Colorado Division of Insurance Regulation 4-2-19.

II. Applicability and Scope

This bulletin only applies to carriers offering and issuing individual health benefit plans to self-employed business groups of one *on or after January 1, 2002*. [Emphasis added.]

III. Division Position

A. Existing law requires an individual carrier to have all applicants complete the "Determination of Self-Employed Business Group of One Form" prior to issuance of an individual policy. The bulletin provides the required form. The form is provided in Attachment I of this bulletin.

Attachment I

Determination of Self-Employed Business Group of One Form

1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?

___ Yes
___ No

2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?

___ Yes
___ No

3. Do you have *gross income* from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? *Note: Substantial part of your income" means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan.* [Emphases added]

___ Yes
___ No

4. Do you work a minimum of 24 hours a week on a permanent basis?

___ Yes
___ No

I, _[name of applicant]_____, attest that the answers to the questions contained in this form are true and correct.

Signature of Applicant: _____

Applicant's business: _____

Date: _____

The "Determination of Self-Employed Business Group of One" form and the application forms being used by the Company in 2003 do not appear to reflect correct or complete questions for this determination to be made. The words "taxable income" are used instead of "gross income" and there is no explanation of what constitutes a "substantial part of your income".

The language in the cited forms reads as follows:

> Do you have *taxable income* from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes which generated *taxable income* in one of the two previous years? [Emphases added]
>
> Have you derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years?

Form Numbers	Form Names
W1130 (12-99)	Determination of Self-Employed Business Group of One Form
G1025-CO	Application Form
G1050-CO (replaced G1025-CO effective 8-25-03)	Application Form

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-8-601.5, C.R.S. and Amended Regulation 4-2-19. In the event the Company is unable to show such proof it should provide evidence to the Division of Insurance that it has revised its Determination of Self-Employed Business Group of One and application forms to reflect correct information as required by Colorado insurance law.

Issue E2: Failure to reflect all required information in application forms concerning replacement of coverage.

Repromulgated Regulation 4-2-1, REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE, promulgated under the authority of §§10-1-109 and 10-3-1110, Colorado Revised Statutes (C.R.S.) states:

Section 2. Purpose

The purpose of this regulation is to safeguard the interests of persons covered by individual accident and sickness insurance policies or plans who consider replacement of their coverage by making available to them information regarding replacement and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance.

Section 5. Rules

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has accident and sickness insurance in force or whether accident and sickness insurance is intended to replace or be in addition to any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used.

[Statements]

(1) You normally do not require more than one policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.

(4) If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

[Questions]

To the best of your knowledge:

(3) Are you covered for medical assistance through the state Medicaid program:

(a) As a Specified Low Income Medicare Beneficiary (SLMB)?

(b) As a Qualified Medicare Beneficiary (QMB)?

(c) For other Medicaid medical benefits?

The Company's applications for insurance in use during 2003 do not appear to reflect any of the statements nor one (1) of the questions required by Colorado insurance law. Question 3, concerning coverage for medical assistance through the state Medicaid program and the three (3) ways an applicant could be covered, are not reflected.

Form Number	Form Name
G1025-CO	Application-Individual-Business Group of One
G1050-CO (replaced G1025-Co effective 08/25/03)	Application Individual-Business Group of One

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Repromulgated Regulation 4-2-1. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its application forms to reflect all required information concerning replacement of coverage.

Issue E3: Failure to display a Fraud Warning that is substantially the same as required by Colorado insurance law.

Section 10-1-128, C.R.S., Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration, states:

> (6) (a) Each insurance company shall provide on all printed applications for insurance, or on all insurance policies, or on all claim forms provided and required by an insurance company, or required by law, whether printed or electronically transmitted, a statement, in conspicuous nature, permanently affixed to the application, insurance policy, or claim form substantially the same as the following:
>
> "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The Company has indicated that it uses the Application Form for displaying the "Fraud Warning" statement. This "Fraud Warning" on the application form in use prior to August 25, 2003 does not appear to be in compliance with Colorado insurance law as the wording is not substantially the same as reflected in Colorado insurance law. The examiners noted that the wording is correct and complete on the application form filed to be effective August 25, 2003.

The wording on the application form in use prior to August 25, 2003 is:

> F. Verification of Information
>
> 3 I acknowledge that:
>
> (e) Please note: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information may be in violation of state law. Use of the mail to defraud is a violation of federal law.

Form Number	Form Name
G1025 CO (used prior to 08/25/03)	Application Form

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-1-128, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms that display the required Fraud Warning statement to reflect substantially the same wording as required by Colorado insurance law.

Issue E4: Failure to disclose the existence and availability of an access plan in the most frequently sold policy in Colorado.

Section 10-16-704, C.R.S., Network adequacy, states:

> (9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204 (3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, *all health benefit plans* and marketing materials *shall clearly disclose the existence and availability of the access plan*. … [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its most frequently sold health benefit plan does not clearly disclose the existence and availability of an access plan for its Sloans Lake and Private Healthcare Systems (PHCS) PPO networks.

Form Number	Form Name
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its health benefit plans to clearly disclose the existence and availability of an access plan for each managed care network it offers in Colorado, to ensure compliance with Colorado insurance law.

Issue E5: Failure to reflect wording that would provide coverage for self-inflicted injuries that may result from a medical condition.

Section 10-16-102, C.R.S., Definitions, states:

(30) "Policy of sickness and accident insurance" means any policy or contract of insurance against loss or expense resulting from the sickness of the insured, or from the bodily injury or death of the insured by accident, or both.

Bulletin 8-99, issued October 22, 1999 states:

Suicide Exclusions And Exclusions For

Intentionally Self-Inflicted Injuries In Health Insurance Policies

Section 1: Background and Purpose

The Division of Insurance ("Division") has received consumer complaints concerning some health insurance carriers' usage and interpretations of suicide exclusions and exclusions for intentionally self-inflicted injuries in their policies. Some carriers are using exclusions to deny coverage for intentionally self-inflicted injuries, including suicide or attempted suicide, even where the injury, suicide or suicide attempt may be the result of sickness, accident or illness, which is covered under the policy. The exclusions at issue use language the same or substantially similar to the following: "benefits are excluded for treatment as a result of attempted suicide or suicide or intentionally self-inflicted injury, whether sane or insane." The purpose for this bulletin is to clarify the Division's position on this issue.

Section 2: Applicability and Scope

The subject matter of this bulletin concerns all health insurance carriers that use exclusions for intentionally self-inflicted injuries, including suicide and suicide attempts in their policies.

Section 3: Division Position

The Division adheres to the opinion of the Colorado courts that suicide, attempted suicide or other acts of self-destruction committed while insane are an accident. Those performing the above acts while insane are incapable of formulating the intent necessary to categorize the act as intentional. Therefore, insurance policies that provide coverage for sickness, accidents and illness, either as may be required by law (such as for mental illness) or otherwise, may not deny coverage for intentional acts committed while insane. Such exclusions are contrary to law and are void as against public policy. Accordingly, carriers are advised to amend policy language and interpret existing policy language accordingly.

The prevailing view in Colorado courts is that broad exclusions for self-inflicted injuries or suicide attempts may not be applied in instances in which the insured or member was "insane" at the time of injury in sickness and accident policies written in Colorado. See e.g., Continental

Casualty Co. v. Maguire, 471 P.2d 636 (Colo. Ct. App. 1970); Metropolitan Life Insur. Co. v. Wright, 480 P.2d 597 (Colo. Ct. App. 1971); Mass. Protective Ass'n v. Daugherty, 288 P. 888(Colo. 1930) (life insurance policy). The reasoning applied by these courts is that injuries sustained in such circumstances are "accidents," not "intentional" acts, since an individual who is insane is incapable of forming the requisite intent.

In addition, Federal HIPAA nondiscrimination provisions (see 29 CFR 2590.702(b)(2)(iii)) do not allow "source of injury" (i.e. self-inflicted) exclusions of benefits otherwise provided for treatment of an injury, if that injury results from a medical condition.

The Company's most frequently sold policy in Colorado in 2003 has an exclusion that does not appear to be in compliance with Colorado insurance law. Benefits for attempted suicide or self-inflicted injuries cannot be excluded if they result from a mental or medical condition (e.g. depression).

The wording in the policy on General Exclusions – Page 1 is:

This policy does not cover:

29. Expenses resulting from suicide or attempted suicide, whether sane or insane, or intentional self-inflicted injury;

Form Number	Form Name
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect wording that provides coverage for attempted suicide and self-inflicted injuries that may result from a mental or medical condition to ensure compliance with Colorado insurance law.

Issue E6: Failure to correctly define and give credit for creditable coverage towards preexisting condition limitations for certain conditions.

Section 10-16-102, C.R.S., Definitions, states:

(13.7) "Creditable coverage" means benefits or coverage provided under:

(a) Medicare or Medicaid;
(b) An employee welfare benefit plan or group health insurance or health benefit plan;
(c) An individual health benefit plan;
(d) A state health benefits risk pool (including but not limited to CoverColorado); or
(e) Chapter 55 of title 10 of the United States code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5 (e) of the federal "Peace Corps Act" (22 U.S.C. Sec 2504 (e)).

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states:

(1) A health coverage plan that covers residents of this state:

(a)(II) If it is an individual health benefit plan … shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the effective date of coverage and *may not define a preexisting condition more restrictively than an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within twelve months*. [Emphasis added.]

(b) *Shall waive any affiliation period or time period applicable to a preexisting condition exclusion or limitation period for the period of time an individual was previously covered by creditable coverage* [emphasis added] if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage. …

The Company's most frequently sold policy in Colorado in 2003 reflects an exclusion of coverage for certain conditions that does not appear to be in compliance with Colorado insurance law. Time delaying certain conditions (not covered during the first six months of a policy unless treated on an emergency basis) is not allowed as it has the ability, and suggests the intent, to avoid giving credit for creditable coverage towards pre-existing condition limitations.

The wording in the policy on General Exclusions and Limitations – Page 1 is:

This policy does not cover:

46. For the following conditions during the first six months this policy is in force, unless such conditions are treated on an emergency basis:

a. Hernia
b. Removal of adenoids and/or tonsils;
c. Varicose veins;
d. Hemorrhoids;
e. Myringotomy or tympanotomy (tubes in ears); or
f. Disorders of the reproductive organs;

Form Number	Form Name
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-102 and 10-16-118, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect correct information concerning the definition and application of preexisting condition limitations as required by Colorado insurance law.

Issue E7: Failure to provide benefits for covered services based on a licensed provider's status, e.g., a family member.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) Reimbursement of providers

(a) Sickness and accident insurance.

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed.

The Company's most frequently sold policy in Colorado in 2003 reflects an exclusion that does not appear to be in compliance with Colorado insurance law. A policy may not exclude reimbursement for covered services performed by a licensed provider if the services are within the scope of the provider's license, and the provider normally charges for the services.

The wording on page 4 of the policy is:

Definitions

Physician
A duly licensed physician who is not a member of a covered person's immediate family, but is one of the following:
1. a Doctor of Medicine or Doctor of Osteopathy;
2. a Doctor of Podiatry or Doctor of "chiropractic; or
3. any other licensed health care practitioner who is required to be recognized by state law and acts within the scope of his/her license.

Provider
A state licensed supplier of health care services and/or supplies who is not a member of a covered person's immediate family.

Form Number	Form Name
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect that benefits may not be denied solely based on a provider's status (e.g. a family member) as required by Colorado insurance law.

Issue E8: Failure to reflect correct covered benefits for prosthetic devices.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(14) Prosthetic devices.

(a) Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit, that provides hospital, surgical, or medical expense insurance *shall provide coverage for benefits for prosthetic devices that equal those benefits provided for under federal laws for health insurance for the aged and disabled* [emphasis added] pursuant to 42 U.S.C. secs. 1395K, 13951, and 1395m and 42 CFR 414.202, 414.210, 414.228 and 410.1000, as applicable to this subsection (14).

(b) For the purposes of this subsection (14) "prosthetic device" means an artificial device to replace, in whole or in part, an arm or leg.

(e) *Repairs and replacements of prosthetic devices are also covered,* subject to copayments and deductibles, unless necessitated by misuse or loss. [Emphasis added]

The description of coverage for prosthetic devices in the Company's most frequently sold policy in Colorado in 2003, appears to be more limiting than is required by Colorado insurance law in the following ways:

1. Nothing is reflected to indicate that repairs of prosthetic devices are to be covered.
2. Replacement coverage is limited to the initial replacement of natural limbs and eyes. Unless necessitated by misuse or loss, all replacements are to be covered.

The wording on pages 1 and 2 of the policy is:

Comprehensive Major Medical Expense Benefit

Covered Expenses

8. Medical supplies as follows:
   b. initial replacement of natural limbs and eyes when loss occurs while the covered person is insured under this certificate;

Form Number	Form Name
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable policy forms to reflect correct covered benefits for prosthetic devices as required by Colorado insurance law.

Issue E9: Failure to reflect correct requirements for individual health plans sold to business groups of one to be regulated as individual plans instead of small group plans.

Section 10-8-601.5, Applicability and scope, C.R.S., states:

(IV)(c)(I) Effective October 1, 1997, the provisions of this article and article 16 of this title concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor if, pursuant to rules adopted by the commissioner, *all of the following conditions are met*: [Emphasis added.]

(B) If the applicant is a business group of one self-employed person, the carrier accepts or rejects such person and, if such person is applying for family coverage, *accepts or rejects the entire family* unless the applicant waives coverage for a family member who has other coverage in effect. [Emphasis added.]

Amended Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One, promulgated pursuant to Sections 10-1-109(1), 10-8-601.5(1)(c)(I) and (3), 10-16-108.5(8), and 10-16-109, C.R.S., states:

III. Applicability And Scope

This amended regulation shall apply to individual health benefit plans marketed and/or newly issued to self-employed business groups of one on or after January 1, 2002.

V. Rules

A. An individual health benefit plan marketed and/or newly issued on or after October 1, 1997, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself, and the application for coverage *meet all the following conditions*: [Emphasis added.]

2. Pursuant to Section 10-8-601.5(1)(c)(I)(B), C.R.S., the carrier issuing the individual health benefit plan coverage *shall accept or reject* a self-employed business group of one who applies for coverage and, if such person is applying for family coverage, his/her entire family (all dependents), unless the applicant waives coverage for a family member who has other coverage in effect. … [Emphasis added.]

The Company has responded to an examiner's inquiry that the most frequently sold policy in Colorado in 2003 was an individual major medical PPO policy, marketed as WorldCareFlex, and sold only to Business Groups of One.

A policy provision in this policy does not appear to be in compliance with Colorado insurance law with regard to one of the required conditions for individual health plans sold to business groups of one to be regulated as individual health benefit plans instead of small group health plans. Unless the business group of one applicant for an individual health benefit plan, who applies for family coverage, waives coverage for a family member because the family member has other coverage in effect, the carrier shall accept or reject the entire family. The policy provision states that the Company reserves the right to specifically exclude from coverage a spouse or dependent children, based on that person's health history,

The wording on Policy Provisions – Page 1 is:

> **Individual Exclusion**
>
> We reserve the right to exclude from coverage you, your spouse or your dependent child(ren) we deem necessary, based on that person's health history. We may require you to sign an amendment to this policy that specifically excludes from coverage a spouse or dependent child(ren). In the event you are excluded from coverage, your dependents are automatically excluded from coverage.

Form Number	Form Name
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-8-601.5, C.R.S. and Amended Regulation 4-2-19. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policies to reflect correct information concerning the requirements for individual health plans sold to business groups of one to be regulated as individual plans instead of small group plans as required by Colorado insurance law.

Issue E10: Failure to reflect complete benefits for mandated preventive child health supervision services.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(11) Child health supervision services.

(a) For purposes of this subsection (11), unless the context otherwise requires, *"child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2),* to dependent children up to age thirteen. [Emphasis added.] Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician.

(b) An individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. Each such plan shall, at a minimum, provide benefits for preventive child health supervision services. …

(c) Benefits for child health supervision services shall be exempt from a deductible or dollar limit provision in any individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident and *such exemption shall be explicitly stated in such a plan.* … [Emphasis added.]

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

Benefit Grid

PART B: SUMMARY OF BENEFITS

9. PREVENTIVE CARE (deductible does not apply)[6]

Footnote 6 See Attachment 1 for list of covered preventive services

Attachment 1

COVERED PREVENTIVE SERVICES	
All Children	Immunization deficient children are not bound by "recommended ages" on immunization chart
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.
Age 3-6	3 well child visits
Age 7-12	3 well child visits

The benefits for child health supervision services reflected in the Company's most frequently sold plan in Colorado do not appear to be in compliance with the requirements of Colorado insurance law in that the following coverages, and information concerning coverage, are not reflected:

1. 1 newborn home visit during the first week of life if the newborn is released from the hospital less than 48 hours after delivery.
2. Immunization deficient children are not bound by "recommended ages" on the current recommendations for routine immunization of infants and children in the United States.
3. The exemptions from a deductible or dollar limit provision do not appear to be stated in the plan.

Additionally, the well child visits are more limiting than required as only three (3) well child visits are reflected as benefits for a child from three (3) years of age to thirteen (13) years of age and six (6) visits are to be provided.

The wording reflected in Definitions – Page 1 of the policy is:

> **Children's Health Care Services**
> Physician-delivered or physician-supervised preventive services for covered dependent children from birth to age 13 with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

The wording reflected in Comprehensive Major Medical Expense Benefits – Page 3 of the policy is:

19. Child preventive health care services on a periodic basis. Such services shall include the following:

a. five child health supervision visits and one Phenylketonuria (PKU) visit from birth through 12 months;
b. two child health supervision visits from 13 months through 35 months; and
c. three child health supervision visits from three years of age to 13 years of age.

Form Number	Form Name
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S., and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms to reflect complete benefits for preventive child health supervision services as mandated by Colorado insurance law.

Issue E11: Failure to reflect correctly and completely the extent of coverage to be provided for home health and hospice care services.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(8) Availability of hospice care coverage.

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions which state clearly and completely the criteria for and extent of insured coverage for home health services and hospice care. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge.

Amended Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of Sections 10-1-109 and 10-16-104(8)(d), C.R.S., states:

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which state *clearly and completely the criteria for and extent of coverage for* home health services and *hospice care* and to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Section 4. Requirements for Home Health Services

A. Definitions.

(3) "*Medical Social Services*" are those services provided by an individual who possesses a baccalaureate degree in social work, psychology or counseling or the documented equivalent in a combination of education, training and experience, which services are provided at the recommendation of a physician for the purpose of assisting the insured or the family in dealing with a specific medical condition. [Emphasis added.]

C. Benefits for Home Health Care Services.

(3) The policy offered shall include benefits for the following services:

(h) *Medical social services:* [Emphasis added.]

Section 5. Requirements for Hospice Care

A. Definitions.

(4) *A "patient/family" is one unit of care consisting of those individuals who are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties*. [Emphasis added.]

(12) *"Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility*. [Emphasis added.]

(18) A "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.

(19) A "hospice per diem" rate is the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

C. Benefits for Hospice Care Services

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem rate with the hospice provider. *Any policy offered shall provide a benefit of no less than $100 per day* for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:

The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days. [Emphasis added.]

(3) *The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above*: [Emphasis added.]

(a) Bereavement support services for the family of the deceased person during the *twelve month period following death*, and in no event shall this maximum benefit be less than $1150. [Emphasis added.]

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may,

except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;

(c) Medical supplies;

(d) Drugs and biologicals;

(e) Prosthesis and orthopedic appliances;

(f) Oxygen and respiratory supplies;

(g) Diagnostic testing;

(h) Rental or purchase of durable equipment;

(i) Transportation;

(j) Physicians services;

(k) Therapies including physical, occupational and speech; and

(l) Nutritional counseling by a nutritionist or dietitian.

The Home Health Care Benefits reflected in the most frequently sold policy in Colorado in 2003 do not completely describe the mandated home health benefits. Medical Social Services are not included in the description of covered services as is required by Colorado insurance law. In addition, the information provided under the "Definitions" section indicates that such services, if required for the insured or the family, would not be considered as covered benefits under the plan.

The wording on pages 3 and 4 of the policy is:

Definitions

Medically Necessary Care or Treatment (Medically Necessary)
Usual and Customary services or supplies provided by a physician, hospital, skilled nursing facility, hospice or other health care provider that we determine are:

3. medically necessary and not primarily for the personal comfort, *social well-being* or convenience of the covered person , the family or the provider; [Emphasis added.]

Hospice Care is automatically provided in the Company's most frequently sold policy in Colorado in 2003. The policy does not appear to reflect correctly and completely the extent of coverage to be provided for hospice care services in the following ways:

One The explanation of who may receive bereavement support services appears to be more limiting than allowed by Colorado insurance law. A patient/family is to be one unit of care consisting not only of the immediate family, but also the primary care giver and individuals with significant personal ties.

The wording in Definitions – Page 3 of the policy is:

> **Immediate Family**
> You, your spouse, the children, brothers, sisters, and parents of either you or your spouse; and the spouses of children, brothers, sisters of either you or your spouse.

The wording in Covered Expenses Subject to Limitations – Page 1 of the policy is:

> Hospice treatment and services are subject to the following requirements and limitations:
>
> 4. Bereavement support services for a deceased covered persons immediate family during the 12-month period following death. Benefits for such services are limited to a maximum of $1,150.

Two Nothing is reflected concerning the benefit for short-term general inpatient (acute) hospice or continuous home care which may be required during a period of crisis, for pain control or symptom management to be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation). This benefit should also reflect:

- The two (2) exceptions (weekends and holidays) for obtaining advance authorization for short-term general inpatient (acute) hospice care or continuous home care during a period of crisis, for pain control or symptom management.

- That prior authorization may not be required if transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day.

Three A lifetime benefit maximum for combined outpatient and inpatient hospice treatment is reflected in the policy that appears to be a more limited amount than required by Colorado insurance law. There is a requirement to provide, if needed, three (3) benefit periods with a determination to be made at that time of the appropriateness of continuing hospice care. The three benefit periods produce an amount of $27,300 and there are eleven (11) additional benefits other than the bereavement support services to be provided that are not included in the hospice per diem rate.

Additionally the policy reflects a separation of outpatient and inpatient hospice treatment with a perdiem amount of $100 for outpatient and $200 for inpatient. This appears to be in contradiction to the requirement to provide at least three (3) benefit periods of three months each,

as the inpatient benefits could exhaust the maximum lifetime benefit amount prior to the insured receiving treatment for these three benefit periods.

The wording in Covered Expenses Subject to Limitations – Page 1 of the policy is:

Hospice treatment and services are subject to the following requirements and limitations:

Covered Expenses Subject to Limitations

… Expenses that exceed the maximums shown in this provision:

1. will not be considered a covered expense under this policy;

Hospice Treatment and Services

Hospice treatment and services are subject to the following requirements and limitations:

3. All covered expenses for this benefit must be billed by the hospice treatment program, or the approved hospice care provider, and will be subject to all the terms of this certificate. This benefit will be paid for expenses actually incurred not to exceed the following limitations:

   a. $100 per day for outpatient hospice treatment.

   b. $200 per day for room and board and treatment while an inpatient in a hospice; and

   c. limited to a maximum lifetime benefit of $27,300 for outpatient and inpatient hospice treatment, combined.

Four Nothing is reflected in the policy identifying the twelve (12) benefits (except for bereavement support services) which are subject to the deductible, coinsurance and stoploss provisions, but are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits. Also, one of these benefits is "transportation" which is excluded by the policy unless specifically provided for.

The wording in General Exclusions – Pages 1 and 2 of the policy is:

General Exclusions and Limitations

This policy does not cover:

42. Transportation charges, except as specifically provided for in this policy;

Five Nothing is reflected in the policy concerning the fact that "Home care services" are hospice services, to be provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

Form Number	Form Name
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. and Amended Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms to disclose to insureds correctly and completely the extent of coverage to be provided for home health and hospice care services as required by Colorado insurance law.

Issue E12: Failure to reflect a required policy provision regarding reinstatement.

Section 10-16-202, C.R.S., Required provisions in individual sickness and accident policies, states:

(1) Except as provided in section 10-16-204, *each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this section* in the words in which the same appear in this section; except that the insurer, at its option, may substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. [Emphasis added.]

(5) (a) *A provision as follows: "Reinstatement:* If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement *and loss due to such sickness as may begin more than ten days after such date.* In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement." [Emphases added.]

The Company's most frequently sold individual policy in Colorado during 2003 does not reflect the required provision regarding reinstatement.

Form No.	Form Name
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-202, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms to correctly reflect all policy provisions required by Colorado insurance law.

Issue E13: Failure to reflect correct information concerning non-renewal of health benefit plans.

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states:

(1) A carrier providing coverage under a health benefit plan shall not discontinue coverage *or refuse to renew such plan except for the following reasons*: [Emphasis added.]

(a) Nonpayment of the required premium;

(b) Fraud or intentional misrepresentation of material fact on the part of the plan sponsor with respect to group health benefit plan coverage and the individual with respect to individual coverage;

(d)(I) The carrier elects to discontinue offering and nonrenew all of its individual, small group, or large group health benefit plans delivered or issued for delivery in this state. In such case the carrier shall provide notice of the decision to discontinue or not to renew coverage to all policyholders and covered persons and to the insurance commissioner in each state in which an affected individual is known to reside at least one hundred eighty days prior to the discontinuance or nonrenewal of the health benefit plan by the carrier. The carrier shall also discontinue and nonrenew all of its individual or small or large group health benefit plans in Colorado. *Notice to the insurance commissioner under this paragraph (d) shall be provided at least three working days prior to the notice to the affected individuals*. [Emphasis added.]

(f) *With respect to individual health benefit plans, the commissioner finds* that the continuation of the coverage would not be in the best interest of the policyholders or certificate-holders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations. *Once the commissioner has made such a finding, the carrier shall provide notice to each covered individual provided coverage of this type of such discontinuation at least ninety days prior to the date of discontinuation* and shall provide each affected covered individual the opportunity to purchase any other individual health insurance coverage being offered by the carrier. In exercising this option, a carrier shall act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage. [Emphases added.]

(4) An individual health benefit plan *must clearly disclose in its contracts and marketing materials the conditions of renewability which conform with the requirements of this section.* [Emphasis added.]

The Company's most frequently sold plan in Colorado in 2003, does not appear to reflect correct information concerning non-renewal of health benefit plans in the following ways:

Incorrect:

The policy reflects the following non-allowable reasons for non-renewal of health benefit plans:

1. Movement outside of the service area

2. Ninety (90) day prior notification at the discretion of the Company

Using a ninety (90) day prior notification of non-renewal of a particular form of individual health plan and offer of any other coverage of the same type is not a decision that can be made solely at the discretion of the Company. This can only be done if one of three (3) specific situations is a finding of and approved by the Commissioner.

The wording on Page 1 of the policy is:

Renewability Provision

We will renew this policy, except for the following reasons:

- Movement outside of service area. If you elected Preferred Provider Organization (PPO) coverage, and no longer live, reside or work in the service area, but only if such coverage is terminated uniformly without regard to any health related factor.

- We elect to nonrenew all policies of this form delivered or issued for delivery to persons in your state. If we non-renew such policies, we will provide:

  (a) advance written notice to you and the commissioner at least 90 days prior to the date of nonrenewal; and
  (b) the option to purchase any other policy that is most comparable to this policy. The new policy will not require evidence of insurability;

- we elect to nonrenew all individual health insurance policies in your state. If we nonrenew such policies, we will provide advance written notice to you and the proper state authority at least 180 days prior to the date of non-renewal.

Form Number	Form Name
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-201.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policies to reflect correct information concerning nonrenewal of both a particular health benefit plan and non-renewal of all plans delivered or issued for delivery in Colorado as required by Colorado insurance law.

Issue E14: Failure to allow life benefits in the event of suicide after the first policy year.

Section 10-7-109, C.R.S., Suicide no defense for nonpayment, states:

> The suicide of a policyholder after the *first* policy year of any life insurance policy issued by any life insurance company doing business in this state shall not be a defense against the payment of a life insurance policy, whether said suicide was voluntary or involuntary, and whether said policyholder was sane or insane. [Emphasis added.] …

The Company's most frequently sold policy in Colorado in 2003 offers, through riders, an optional benefit of life insurance for the insured and/or a covered spouse in the amount of $10,000. From January 1, 2003 through March 9, 2003 life benefit riders were used that reflected a suicide clause that appears to be more restrictive than allowed by Colorado insurance law. The riders were amended as of March 10, 2003 to reflect, as required by Colorado insurance law, the correct information concerning when life benefits would be payable in the event of suicide.

The wording in the riders prior to March 10, 2003 was:

Life Insurance Benefit

Suicide Clause

No benefits are payable for a loss resulting from suicide, if such loss occurs within the first two years from the Policy Date, as shown in the Validation of Coverage.

If the covered (member) (spouse) dies by suicide within the first two years from the Policy Date, we will refund the premium paid by the covered (member) (spouse) for this rider.

Form Number	Form Name
R1146-CO	Life Benefits for Insured Rider
R1147-CO	Life Benefits for Covered Spouse Rider

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-7-109, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it provided all affected policyholders with revised policy riders reflecting correct information concerning defenses against payment of life insurance benefits in the event of suicide as required by Colorado insurance law.

Issue E15: Failure to reflect the correct percentage of late payment interest to be paid on benefits.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

> (4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.
>
> (5) (a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, *interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due* pursuant to subsection (4) of this section. [Emphasis added.]

The provision for the Time of Payment of Claims as stated in the Company's most frequently sold individual policy in Colorado, does not reflect correct information. This provision reflects that the Company will pay interest on the benefits due at a rate of eighteen percent (18%) per year if they fail to comply with their "payment of claim" rules. This provision does not correctly relay the Company's intent or practice as it pays ten percent annually on late payment amounts.

The wording on Claims Provisions – Page 1 is:

Claims Provisions

Time of Payment of Claim

…If payment will be denied or delayed in whole or in part, we will write you within 15 working days telling why and listings the things we need to process (the rest of the) claim. As soon as we receive from you all the things we listed, we will either process the claim or write you within 15 working days …

If we do not comply with the rules above, we will pay interest on the benefits due at the rate of 18% per year.

Form No.	Form Name
A4024	WorldCareFlex (marketing name) Major Medical PPO Policy

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policies to reflect accurate information concerning the payment of interest *and penalties* for claims that are not paid, denied, or settled within the time periods required by Colorado insurance law.

UNDERWRITING
APPLICATIONS
FINDINGS

Issue G1: Failure to automatically provide Colorado Health Plan Description Forms during the application process.

Section 10-8-601.5(1)(c)(I), C.R.S., Applicability and scope, states:

> Effective October 1, 1997, the provisions of this article and article 16 of this title concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met:
>
> (E) … The individual carrier shall provide to the business group of one self-employed applicant a copy of the health benefit plan description form for the Colorado standard health benefit plan in addition to the description form for the individual plan being marketed. …

Amended Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One, promulgated pursuant to Sections 10-1-109(1), 10-8-601.5(1)(c)(I) and (3), 10-16-108.5(8), and 10-16-109, C.R.S., states:

> V. Rules
>
> A. An individual health benefit plan marketed and/or newly issued on or after October 1, 1997, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself, and the application for coverage meet all the following conditions:
>
> 5. A carrier issuing an individual health benefit plan to a self-employed business group of one shall abide by the disclosure requirements as described in Section 10-8-601.5(1)(c)(I)(E), C.R.S. Accordingly:
>
> b) The carrier *must* provide the applicant with a Colorado Health Plan Description Form for the state's Standard Health Benefit Plans, available from the Colorado Division of Insurance. Carriers may reproduce and distribute this form in order to comply with the provisions of Section 10-8-601.5(1)(c)(I)(E), C.R.S. [Emphasis added.]

Amended Regulation 4-2-20, Concerning The Colorado Comprehensive Health Benefit Plan Description Form, promulgated pursuant to Sections 10-1-109, 10-3-1110(1), 10-16-108.5(11)(b), and 10-16-109, C.R S., states:

> Section 4. RULES

E. Carriers shall provide a Colorado Health Plan Description Form as follows:

b. *Automatically* within three (3) business days of a potential policyholder expressing interest in a particular plan (e.g., "I am interested in the Gold Plan, the $500 deductible PPO plan, your Medicare HMO plan with vision care coverage, etc.," or "I want to purchase your Plan 200, $5 copay HMO plan," etc.): [Emphasis added.]

F. 1. Carriers shall prominently include with all marketing materials the following notice:

"Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. *The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan*. … [Emphasis added.]

Bulletin 2-98, Distribution and Use of the Colorado Comprehensive Health Benefit Description Form, Issue and Effective Date: April 14, 1998, states:

I. BACKGROUND & PURPOSE

In 1997, the Colorado General Assembly passed legislation (HB 97-1311) requiring all carriers to use a standard benefit description form for health benefit plans issued or renewed on and after January 1, 1998. (See Section 10-16-108.5(11), C.R.S.) In November 1997, the Division of Insurance promulgated Insurance Regulation 4-2-20, which established and implemented rules concerning the format for, elements of, and issuance of the Colorado Health Benefit Description Form. Both the regulation and HB 97-1311 specified the circumstances under which the form must be distributed.

It has come to the attention of the Division of Insurance that some carriers are not following the rules for distributing the form. …
The purpose of this bulletin is (1) to remind carriers of Colorado's requirements concerning the distribution of the Colorado Health Benefit Description Form,

II. ACTION NECESSARY

A. Carriers are reminded that Colorado Insurance Regulation 4-2-20 requires all carriers to provide a Colorado Health Plan Description Form, which is specific with respect to the particular policy provisions of the policy it is marketing, selling, or has issued, under the following circumstances:

3. As part of the policyholder's and, if different, the certificate holder's *application for coverage before an application for coverage is actually filled out;* [Emphasis added]

Bulletin No. 12-01, Determination of Self-Employed Business Group of One Form and Disclosure form for Self-Employed Business Groups of One Applying for Individual Health Benefit Plans, states:

> III. Division Position
>
> B. Existing law requires an individual carrier, as part of its application form, to obtain a signed disclosure from a self-employed business group of one that is applying for an individual health benefit plan. The form shall include the following statements:
>
> "Please read and sign the following disclosure required by Colorado law:
>
> *I have been given* a health plan description form showing the benefits under Colorado's small group Standard Health Benefit Plans. *I have also been given* a Colorado Health Plan Description Form for the plan for which I am applying." [Emphases added.]

When requested to describe the method used and how documentation could be provided that the Company distributed a Colorado Health Plan Description Form (CHPDF) during the application process, a copy of Form M1110, edition date of 09/03 was provided with the following response:

> We created Form M1110, notified the field this form was to be given to the prospect/applicant, notified the field the Health Plan Description forms are on the website and in print form in supply.

Form M1110, (9-03) reads:

> **Colorado Health Plan Description Notice**
>
> Colorado law requires that we make available to you a Colorado Health Plan Description Form, which is intended to facilitate your comparison of health plans. The form must be provided to you automatically within three (3) business days, if you expressed an interest in a particular plan. We must also provide the form, upon your oral or written request, within three (3) business days, if you are interested in coverage or you currently have coverage with us.

The Company was asked what method of field notification was used to indicate the CHPDF was to be automatically provided prior to the 09/03 edition date of Form M1110 and the response was:

> Prior to the use of the M1110 the disclosure forms were made available to the agents for their use and communications such as the attached letters were used. …

The wording in the attached letters was:

> **Colorado Individual Business Group of One**
> **WorldCare Flex Product Information**
>
> - **What other forms are available for review?**

1. **Colorado Health Plan Description forms.** These forms are available on World's website, www.worldsells.com, under the Print Forms section. WorldCare Flex, Individual Business Group of One and WorldCare HDHP each have health plan description forms appropriate to their plan options. If requested by the prospect, the appropriate form relating to the plan selected must be delivered within three days.
2. **Colorado State Health Plan Description form.** This state form is available on the Colorado Department of Insurance website at www.dora.state.co.,us/insurance/regsb11-01. If your prospect requests this form, it must be delivered within three days.

The Company also provided a copy of an October 14, 2003, WorldWire – World Insurance Company directive that stated on pages 2 and 3:

> **Colorado Change Announced**
> Agents selling major medical insurance in the state of Colorado should be aware that at the time of application, a Health Plan Description form must be left with the client. The list below shows which form should be used for each plan. Forms are listed by form number, version date and description.
>
> Agents must also give the client the Colorado Plan Description Notice, form # M1110, at the time of the application. All Colorado Health Plan Description forms and the Plan Description Notice are available on World's Virtual Home Office, www.worldsells.com.

The procedures used by the Company prior to September 2003, do not appear to meet Colorado insurance law with regard to the requirement to automatically provide Colorado Health Plan Description Forms as part of the policyholder's, and if different, the certificate holder's application for coverage before an application for coverage is actually filled out.

The Company's "Disclosure & Certificate" Form for Business Groups of One, does not appear to be in compliance with Colorado insurance law as it reflects only that the applicant is aware that Colorado Health Plan Description Forms (CHPDFs) forms are available if an applicant requests them. The correct disclosure wording should reflect the required action of the Company by stating that the applicant has been automatically given the CHPDF's as part of the application process.

The wording in the "Disclosure & Certificate" Form is:

> I am aware that a health plan benefit description form showing the benefits under Colorado's Small Group Standard Health Benefits Plan is available at my request. I am also aware that a Colorado Health Plan Description form for the plan for which I am applying is available upon request.

Form Number	Form Name
W1133 (6-03)	Disclosure & Certificate

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-8-601.5, C.R.S., Amended Regulations 4-2-19 and 4-2-20. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that Colorado Health Plan Description Forms are automatically provided during the application process as required by Colorado insurance law.

UNDERWRITING
CANCELLATIONS/NON-RENEWALS/DECLINATIONS
FINDINGS

Issue H1: Failure to reflect correct or complete information on Certificates of Creditable Coverage.

Amended Regulation 4-2-18, Concerning The Method of Crediting and Certifying Creditable Coverage For Pre-existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states:

II. Purpose And Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage when determining exclusions for pre-existing conditions as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 1999 amendments to this regulation is to update the regulation as part of the Executive Order Review Process (Executive Order D0004 97).

III. Applicability And Scope

This amended regulation shall apply to all health coverage plans which are issued or renewed on or after November 1, 1999.

V. Rules

A. Application of federal laws concerning creditable coverage

1. The method for crediting and certifying creditable coverage for determining pre-existing condition limitations, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in federal regulations promulgated pursuant to HIPAA, with the following exceptions:

    a. Those exceptions specifically enumerated in this regulation; and

    b. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.

2. The federal regulations found in 45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; 45 C.F.R. 146.117: 45 C.F.R. 146.119(b); and 45 C.F.R. 146.125 (a)(3), (b) (d) and (e) adopted by the Department of Health and Human Services are hereby incorporated by reference, and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S. These federal regulations concern methods of counting creditable coverage, requirements concerning a health plan's duty to provide certificates of creditable coverage to insureds, special enrollment periods, the effective dates for certification requirements, transition rules for counting creditable coverage, and transition rules for certificates of creditable coverage. This rule does not include later amendments to, or editions of, the above-referenced regulations. Interested parties are encouraged to refer to the summary and supplementary information concerning the incorporated regulations which begins in Volume 62,

number 67, page 16894 of the Federal Register, April 8, 1997, for assistance in interpreting the federal regulations.

A certificate of creditable coverage is intended to establish an individual's prior creditable coverage for purposes of reducing the extent to which a plan or issuer offering health coverage in the group market can apply a preexisting condition exclusion. Two (2) of the items required to be disclosed in the certificate of creditable coverage are:

1. The correct date coverage began and ended
2. As of July 1, 1998, the names and individual dates of coverage of dependents

During the review of the fifty (50) Cancelled/Non-Renewed files it was noted that some of the Certificates of Creditable Coverage reflected incorrect dates of termination and/or failed to reflect the names of any dependents to whom the certificate applied. The "paid-to-date" in the Company's administrative LifePro system, (used for storing all information on a policy) appears to be transferring as the termination date on the Certificate of Creditable Coverage. In some instances this was noted to be different than the actual termination date requested by the insured and displayed on the notification of termination sent to the insured.

No. on Sample List	Date Coverage Terminated	Termination Date Reflected on COCC
1	04-21-03	05-05-03
2	02-06-03	02-27-03
16	03-01-03	03-17-03
20	02-11-03	05-05-03
28	04-01-03	04-15-03
44	04-16-03	09-01-03
49	03-06-03	04-03-03
50	04-08-03	04-21-03

Additionally, this Certificate of Creditable Coverage reflects an incorrect date of 12-21-03 that a completed application was received and that coverage began.

No. on Sample List	Subscribers	Dependents Reflected on COCC
2	2	None
20	2	None
30	3	None

33	4	None
49	5	None

CANCELLED/NON-RENEWED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
1,005	50	10	20%

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that Certificates of Creditable Coverage reflect correct and complete information in compliance with Colorado insurance law.

CLAIMS
FINDINGS

Issue J1: Failure in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(1) The general assembly finds, determines, and declares that:

(a) Patients and health care providers often do not receive the reimbursements to which they are entitled from health insurance entities in a timely manner, even in the case of claims that are submitted on standard forms and do not require additional information for processing; and

(b) Unnecessary delays in the payment of routine and uncontested claims for reimbursement represent an unwarranted drain on health care providers' resources, which could be better spent attending to the needs of patients, as well as wasting the time and money of the patients themselves. Therefore, it is in the interest of the citizens of Colorado that reasonable standards be imposed for the timely payment of claims.

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

Paid and Denied Claims Received Electronically in 2003 Exceeding 30 Days

Data provided by the Company indicated a population of 9,782 paid and denied individual claims received electronically in 2003. The examiners identified 842 claims from this population as taking over thirty (30) days from date of receipt to process. A randomly selected sample of fifty (50) claim files was taken from these 842 files. Eighteen (18) of the claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time period.

PAID AND DENIED ELECTRONIC CLAIMS OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
842 *	50	18	38%

*(9% of all paid and denied electronic claims)

Paid and Denied Claims Received Non-Electronically in 2003 Exceeding 45 Days

Data provided by the Company indicated a population of 13,344 paid and denied individual claims received non-electronically in 2003. The examiners identified 1,444 claims from this population as taking over forty-five (45) days from date of receipt to process. A randomly selected sample of fifty (50) claim files was taken from these 1,444 files. Twenty-two (22) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time period.

PAID AND DENIED NON-ELECTRONIC CLAIMS OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
1,444 *	50	22	44%

*(11% of all paid and denied non-electronic claims)

Paid and Denied Claims Received in 2003 Exceeding 90 Days

Data provided by the Company indicated 23,126 paid and denied individual claims received in 2003. The examiners identified 492 claims from this population of 23,126 as taking over ninety (90) days from date of receipt to process. None of these 492 claims appeared to involve fraud. These claims do not appear to have been paid, denied or settled as required by Colorado insurance law with respect to the ninety (90) day time period.

CLAIMS NOT PAID, DENIED OR SETTLED WITHIN NINETY (90) DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
492*	N/A	492	100%

(*2% of all paid and denied claims)

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all claims are paid, denied or settled within the time periods required by Colorado insurance law.

Issue J2: Failure to accurately determine the number of days utilized for claim processing.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

Section 10-16-121, C.R.S., Required contract provisions in contracts between carriers and providers, states:

(1) A contract between a carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan shall make provisions for the following requirements:

(c) Any contract providing for the performance of claims processing functions by an entity with which the carrier contracts shall require such entity to comply with section 10-16-106.5 (3), (4), and (5).

The data being entered into the Company's claim system and used for computing the days from receipt of claim until the check/explanation of benefits is mailed to the claimant (processing time) appears to be producing an incorrect number of days as indicated by the following procedures which have been in place for Colorado claims since May 14, 2001.

1. Insureds and providers are instructed to initially submit their claims to World Insurance Company. Providers can submit claims electronically via WebMD to World's Payor ID and this Payor ID number is printed on ID cards. The Company uses an outside vendor, ECOM PPO, for repricing and the following two (2) network providers:

    - Sloans Lake Managed Care
    - Private Healthcare Systems (PHCS)

1. The Company has indicated that claims received directly by it are keyed into its system, (dids_key_date) and then forwarded to ECOM for repricing. If the claim is returned without repricing, the key date is used as the receipt date for determination of processing/interest days. If the claim required additional information for processing (e.g. repricing), the "dids_all_info_date" is the date used to calculate processing/interest days.

2. The process date being entered in the Company's system and used to compute the processing time is the date the claims system adjudication is completed by the claims examiner. Payment of benefit checks are run on a weekly cycle after the claim is adjudicated producing an additional number of days to process that are not being used in the calculation of the period of time to process a claim.

3. If the Company's claims system using the above procedures, considers the claims (30 days used for both paper and electronically received due to system limitations) to have been processed within the required time periods, the Paid/Denied processing days produced is -0-. Although it would appear that this procedure would allow the claims system to determine if late payment interest/penalty should be paid, (interest was system generated in 2003), it would not provide an accurate trigger of when a claim is not processed within the required time period based on the processing time produced by the system.

The procedures being used by the Company appear to result in an inability to accurately track the number of days utilized for processing of claims and to determine in all instances those for which late payment interest and penalties would apply. Carriers cannot avoid their statutory obligations regarding the amount of time allowed for processing claims without interest/penalty being due because an intermediary repricer is involved.

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-106.5 and 10-16-121, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established the necessary procedures to ensure accuracy in determining the number of days required to process claims and calculate interest due on late claims in compliance with Colorado insurance law.

Issue J3: Failure, in some cases, to accurately process claims.

Section 10-3-1104(1), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

(f) Unfair discrimination states:

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part II or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; . . .

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(11) Child health supervision services.

(a) For purposes of this subsection (11), unless the context otherwise requires, "child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2), to dependent children up to age thirteen. Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician.

(b) An individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. Each such plan shall, at a minimum, provide benefits for preventive child health supervision services. …

(c) Benefits for child health supervision services shall be exempt from a deductible or dollar limit provision in any individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident and such exemption shall be explicitly stated in such a plan. …

Randomly selected samples were chosen for review of processing from the population of individual paid and denied claims received from January 1, 2003 through December 31, 2003. The populations, sample sizes, number of exceptions and percentage to the sample are reflected below.

INDIVIDUAL PAID CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
20,071	100	5	5%

INDIVIDUAL DENIED CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,055	50	3	6%

The claims cited on the Comment Forms identified below do not appear to have been processed correctly:

1. Comment Form No. J2
Denied Claim

2. Comment Form No. J2-First Addendum
Denied Claim

3. Comment Form No. J2-Second Addendum
Denied Claim

4. Comment Form No. J2-Third Addendum
Paid Claim

5. Comment Form No. J2-Fifth Addendum
Paid Claim

6. Comment Form No. J2-Sixth Addendum
Paid Claim

7. Comment Form No. J2-Seventh Addendum
Paid Claim

8. Comment Form No. J2-Eighth Addendum
Paid Claim

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104 and 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that claim processing staff are adequately trained and monitored to ensure accuracy of payment as required by Colorado insurance law.

Issue J4: Failure to pay applicable late payment penalties and in some cases, late payment interest.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

In response to the examiner's inquiry concerning late payment penalties, the Company responded that the claim examiners overlooked the penalty requirements (manual process) and only the interest (system generated) was paid. The Company indicated this was a training issue that would be addressed and that they were working on a system enhancement to figure penalties in the future.

The Company's ATLAS claims system automatically computes late payment interest that is paid concurrently with the claim. The days used to trigger payment of this interest was changed in error on March 1, 2003 from 30 days to 90 days. As a result, it appears that applicable late payment interest was not paid in all instances for ten (10) months of the 2003 year under examination, and for three (3) months of 2004. This error was discovered during the market conduct examination and the interest table was corrected as of April 1, 2004 and is now being computed correctly.

The Company conducted a self-audit during the examination to identify and pay any interest and penalties that were due.

Recommendation No. 23:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that late payment interest and penalties are paid in all required instances as required by Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

Independent Market Conduct Examiners

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP

Lynn L. Zukus, AIE, FLMI

for
The Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202

participated in this examination and in the preparation of this report.